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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREAS FISCHER** **5023 S. Lee Circle** **Spokane, WA 99223** **Registered Nurse License No. 621653** **Public Health Nurse Certification No. 66906** Respondent.	Case No. 2011-206 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about July 14, 2003, the Board issued Registered Nurse License Number 621653 to Andreas Fischer ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2011, unless renewed.

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3. On or about September 15, 2003, the Board issued Public Health Nurse Certification Number 66906 to Respondent. The Public Health Nurse Certification was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2011, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

STATUTORY AND REGULATORY PROVISIONS

5. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

8. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

9. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

10. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

COSTS

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

12. On or about June 22, 2005, at approximately 8:50 p.m., patient J.W.[1] was admitted to zone one of the emergency department at San Francisco General Hospital in San Francisco, California, where he was diagnosed with pneumonia, acute renal failure, and possible sepsis. At approximately 8:55 p.m. on June 22, J.W. was given one liter of fluids. At approximately 9:50 p.m., a physician ordered that J.W. be administered Vancomycin. J.W. received a second liter of fluids at approximately 10:35 p.m.

13. At approximately 11:00 p.m., Respondent was assigned to care for J.W. At 11:20 p.m., Respondent charted J.W.'s vital signs, including his blood pressure, heart rate, respiratory rate, and pulse oximetry. Under the notes section next to the 11:20 p.m. chart entry, Respondent wrote that J.W. should start oxygen therapy. Respondent did not, however, notify the physician on duty of the need for oxygen therapy.

14. At approximately 11:55 p.m., J.W. was given 1,150 cc of fluid, bringing the total amount of fluid he had received since 8:55 p.m. to 3,150 cc. Respondent did not notify the physician on duty of the potential for fluid imbalance. Nor did he assess or chart J.W.'s response to the fluid.

15. At approximately 12:40 a.m. on the morning of June 23, 2005, Respondent charted J.W.'s vital signs a second time. Under the notes section next to the 12:40 a.m. chart entry,

[1] Initials are utilized herein to protect patient privacy. The patient's name will be released to Respondent upon request in discovery.

Respondent wrote: "Pt more confused. Pulled out IV. Restraints placed." Respondent did not provide further explanation as to why J.W. was more confused. Nor did he document the type of restraints applied, restraint checks, alternatives tried, or the time the restraints were removed.

16. At approximately 2:45 a.m., a nurse administered 1 mg of Ativan to J.W. Respondent did not assess or chart J.W.'s response to this medication. Shortly after J.W. received the dose of Ativan, Respondent took him to the radiology department to receive a CT scan. Respondent did not document this trip in J.W.'s chart. The CT scan was unsuccessful, and Respondent brought J.W. back to the emergency department.

17. At approximately 3:30 a.m., J.W. was given a dose of Gastrografin to prepare him for a second CT scan. Respondent did not document this medication in J.W.'s chart.

18. At approximately 3:30 a.m., 3:40 a.m., and 3:50 a.m., Respondent administered three separate doses of Versed 2 mg IV to J.W. Respondent did not, however, assess or chart J.W.'s response to this medication.

19. Sometime after Respondent administered the doses of Versed to J.W., he took him to the radiology department for a second CT scan. Respondent brought J.W. back to the emergency department at approximately 4:00 a.m. Respondent did not document this trip in J.W.'s chart.

20. While J.W. was being transported to and from the emergency and radiology departments, Respondent did not place him on a portable transport monitor.

21. Sometime between 4:33 a.m. and 5:10 a.m., Respondent wrote in J.W.'s chart that he had administered the Vancomycin ordered by the physician at 9:50 p.m. on June 22 at 11:50 p.m. on June 22. Under the notes section next to the 11:50 p.m. chart entry, Respondent wrote "late entry."

22. Between 12:40 a.m. and 4:12 a.m. on June 23, Respondent did not make any entries in J.W.'s chart other than certain medication orders.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), of the Code, and California Code of Regulations, title 16, sections 1443 and 1443.5(1), (3), and (5),

for incompetence in that Respondent (1) failed to take and chart J.W.'s vital signs between 12:40 a.m. and 4:12 a.m. on June 23, 2005; (2) failed to notify the physician on duty of J.W.'s need for oxygen therapy and his potential for fluid imbalance; (3) failed to assess and chart J.W.'s response to treatment and interventions, including the 3,150 cc of fluid, the Ativan, and the Versed; (4) failed to chart a physician's order for Gastrografin; (5) failed to document the type of restraints applied to J.W., restraint checks, alternatives tried, or the time the restraints were removed; (6) failed to chart the dose of Vancomycin at the time of administration; (7) failed to chart J.W.'s two trips to and from the emergency and radiology departments; and (8) failed to monitor J.W.'s condition with a portable transport monitor during his two trips to and from the emergency and radiology departments.

The circumstances of Respondent's conduct are set forth above in paragraphs 12 through 22.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), of the Code, and California Code of Regulations, title 16, section 1442, for gross negligence in that Respondent (1) failed to take and chart J.W.'s vital signs between 12:40 a.m. and 4:12 a.m. on June 23, 2005; (2) failed to notify the physician on duty of J.W.'s need for oxygen therapy and his potential for fluid imbalance; (3) failed to assess and chart J.W.'s response to treatment and interventions, including the 3,150 cc of fluid, the Ativan, and the Versed; (4) failed to chart a physician's order for Gastrografin; (5) failed to document the type of restraints applied to J.W., restraint checks, alternatives tried, or the time the restraints were removed; (6) failed to chart the dose of Vancomycin at the time of administration; (7) failed to chart J.W.'s two trips to and from the emergency and radiology departments; and (8) failed to monitor J.W.'s condition with a portable transport monitor during his two trips to and from the emergency and radiology departments.

The circumstances of Respondent's conduct are set forth above in paragraphs 12 through 22.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 621653 issued to Andreas Fischer;

2. Revoking or suspending Public Health Nurse Certification Number 66906 issued to Andreas Fischer;

3. Ordering Andreas Fischer to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 9/8/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2010201808